DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 2 4

2. STATE: Montana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
070101

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 975,225
b. FFY _____ $ _____

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B 1-7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B 1-6

10. SUBJECT OF AMENDMENT:
Reimbursement for Outpatient Hospital

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Single State Agency Director

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Michael S Billings for

13. TYPED NAME:
Gail Gray

14. TITLE:
Director

15. DATE SUBMITTED:
28 September 2001

16. RETURN TO:
Department of Public Health & Human Services
Gail Gray Director
Attn: Denny Gemmell
PO Box 202951
Helena MT 59620

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
October 3, 2001

18. DATE APPROVED:
December 26, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Spencer K. Ericson

21. TYPED NAME:
Spencer K. Ericson

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: September 28, 2001

REIMBURSEMENT FOR OUTPATIENT HOSPITAL SERVICES

A. COST BASED RETROSPECTIVE REIMBURSEMENT

Except for those services reimbursed as provided for in Subsection B and the facilities identified in Subsection D, all outpatient hospital services for all facilities identified in Subsection C, will be reimbursed on a retrospective basis. The reimbursement period will be the provider's fiscal year.

Cost of hospital services will be determined for inpatient and outpatient care separately. Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, HCFA Pub. 15-1, subject to the exceptions and limitations provided in the Department's Administrative Rules. Pub. 15, is a manual published by the United States Department of Health and Human Services, Health Care Financing Administration, which provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

All facilities identified in Subsection C will be reimbursed on an interim basis during the facility's fiscal year. The interim rate will be a percentage of usual and customary charges. The percentage shall be the provider's cost-to-charge ratio determined by the facility's Medicare intermediary or by the Department under Medicare reimbursement principles, based upon the provider's most recent Medicare cost report. If a provider fails or refuses to submit the financial information, including the Medicare cost report, necessary to determine the cost to charge ratio, the provider's interim rate will be 50% of its usual and customary charges.

All In-State and Border hospitals will be required to submit a Medicare cost report in which costs have been allocated to the Medicaid program as they relate to charges. The facility shall maintain appropriate accounting records which will enable the facility to fully complete the cost report. Upon receipt of the cost report, the Department will instruct the Medicare intermediary to perform a desk review or audit of the cost report and determine whether overpayment or underpayment has resulted.

Facilities will be required to file the cost report with the Montana Medicare intermediary within 150 days of the facility's fiscal year end or receipt of the department cost settlement detail reports, whichever is later.

Except as identified below, Medicare principles of reasonable cost reimbursement will be applied to cost settlement of those outpatient hospital services which are identified as being subject to cost based retroactive reimbursement:

For each hospital which is not a sole community hospital,

reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined less 7.0% of such costs.

For each hospital which is a sole community hospital, reimbursement for reasonable costs of outpatient hospital services, other than the capital-related costs of such services, shall be limited to allowable costs, as determined less 1.2% of such costs.

B. PROSPECTIVE REIMBURSEMENT

Except as otherwise specified, the following outpatient hospital services for all facilities identified in subsection C, will be reimbursed under a prospective payment methodology for each service as described as follows:

1. CLINICAL DIAGNOSTIC LABORATORY SERVICES

Clinical diagnostic laboratory services will be reimbursed on a fee basis which is the lesser of the provider's usual and customary charge or the applicable percentage of the Medicare fee schedule as follows: 60% of the prevailing Medicare fee schedule when a hospital laboratory acts as an independent laboratory, i.e., performs tests for persons who are non-hospital patients; 62% of the prevailing Medicare fee schedule for a sole community hospital; 60% of the prevailing Medicare fee schedule for a hospital not designated as a sole community hospital. For clinical diagnostic laboratory services where no Medicare fee has been assigned, the fee is 62% of usual and customary charges for a hospital designated as a sole community hospital; or 60% of usual and customary charges for a hospital that is not designated as a sole community hospital. Clinical diagnostic laboratory services include the laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology, Fourth Edition (CPT-4). Certain tests are exempt from the fee schedule. These tests are listed in the HCFA Pub-45, State Medicaid Manual, Payment For Services, Section 6300. These exempt clinical diagnostic laboratory services will be reimbursed under the retrospective payment methodology.

2. EMERGENCY ROOM & CLINIC SERVICES

Emergency room and clinic services provided by hospitals that are not isolated hospitals or critical access hospitals will be reimbursed on a fee basis for each visit. Emergency room and clinic services will be classified into one of three service groups for reimbursement purposes. Each service group will have two fees, one for sole community hospitals and one for non-sole community hospitals. Payment will be on a partially bundled basis (that is, hospitals will continue to be reimbursed separately for lab and

imaging services but all other services on that day are bundled into the payment rates). The three service groups are defined as follows:

- Critical Care/Transfers: Critical emergency room visits are emergency room visits in which the recipient receives critical care procedures, dies while in the emergency room or is discharged or transferred to another short term general hospital for inpatient care. Critical care procedures are those procedures designated by the department as such and identified in the department's emergency room critical care procedures list.

- Emergency Room Visits: Emergency visits are emergency room visits for which the ICD-9-CM diagnosis code chiefly responsible for the services provided is a diagnosis designated as an "Always Emergent" diagnosis in the Medicaid PASSPORT program Emergency Diagnosis List. The Passport Emergency Diagnosis List is periodically updated by the Montana Medicaid Provider Education Review Committee.

- Other ER/Clinic Visits: Other emergency room and clinic visits are emergency room and clinic visits that do not meet the criteria for the critical or emergency visit groups as specified above. These visits are "Perhaps Emergent" and have been authorized by the PASSPORT provider.

The fees for emergency room and clinic service groups as described above for sole community hospitals and non-sole community hospitals are specified in the department's outpatient hospital emergency room & clinic fee schedule.

The fees for emergency room and clinic service groups are an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, supplies, equipment and other outpatient hospital services. Physician services are separately billable according to the applicable rules governing billing for physician services. In addition to the fee specified for each emergency room and clinic service group, Medicaid will reimburse providers separately for laboratory, imaging and other diagnostic services provided during emergency and clinic visits.

For hospital emergency room and clinic visits determined by the department to be unstable, the fee will be a stop-loss payment. If the provider's net usual and customary emergency room or clinic charges are more than 500% or less than 75% of the fee specified, the visit is unstable and the net charges will be paid at the statewide outpatient cost to charge ratio. For purposes of the stop-loss provision, the provider's net emergency room or clinic charges are defined as total usual and

customary claim charges less charges for laboratory, imaging, other diagnostic and any non-covered services.

Emergency visits as defined above with ICD-9-CM surgical or major diagnostic procedure codes will be grouped into one of the ambulatory surgery day procedure groups.

3. EVALUATION AND STABILIZATION SERVICES

Emergency room services provided to a PASSPORT recipient with a diagnosis not on the Emergency Diagnoses Exempt from PASSPORT list and when the PASSPORT provider has not authorized the services, will be reimbursed a prospective fee of $20.60 per emergency room visit plus ancillary reimbursement for laboratory, imaging and other diagnostic services. The fee is a bundled payment per visit for all outpatient services provided to the patient including, but not limited to, nursing, pharmacy, supplies and equipment and other outpatient hospital services.

4. DIALYSIS SERVICES

Dialysis visits will be reimbursed at the provider's Medicare composite rate for dialysis services determined by Medicare under 42 CFR 413 subpart H. The facility's composite rate is a comprehensive prospective payment for all modes of facility and home dialysis and constitutes payment for the complete dialysis treatment, except for a physician's professional services, separately billable laboratory services and separately billable drugs. The provider must furnish all of the necessary dialysis services, equipment and supplies. Reimbursement for dialysis services and supplies is further defined in the Medicare Provider Reimbursement Manual, HCFA Pub. 15 (referred to as "Pub. 15"). For purposes of specifying the services covered by the composite rate and the services that are separately billable, the department hereby adopts and incorporates herein by reference Pub. 15.

5. IMAGING AND OTHER DIAGNOSTIC SERVICES

Imaging services will be reimbursed the lesser of the provider's usual and customary charges or a fee basis. For each imaging service or procedure, the fee is 100% of the technical component of the medicare Ambulatory Payment Classification (APC) rate. Where no medicare fee has been assigned for an imaging service, the fee is 62% of usual and customary charges for a hospital designated as a sole community hospital or 60% of usual and customary charges for a hospital designated as a non-sole community hospital. The imaging services reimbursed under this plan are those individual imaging services listed in the 70000 series of the Current Procedural Terminology, Fourth Edition (CPT-4).

Other Diagnostic Services will be reimbursed the lesser of the provider's usual

and customary charges or the Medicaid fee. For each diagnostic service or procedure, the fee is 100% of the technical component of the medicare Ambulatory Payment Classification (APC) rate. If there is no Medicare APC rate for the procedure, reimbursement will be 62% of usual and customary (billed) charges for a hospital designated as a sole community hospital and 60% of usual and customary (billed) charges for a hospital that is not designated as a sole community hospital. The individual diagnostic services reimbursed under this plan are those listed in the Current Procedural Terminology, Fourth Edition (CPT-4).

6. AMBULATORY SURGERY SERVICES

Ambulatory surgery services provided by hospitals that are not isolated hospitals or critical access hospitals will be reimbursed on a fee basis. A separate fee will be paid within each day procedure group depending on whether or not the hospital is a sole community hospital. Payment for ambulatory surgery services is a fee for each visit determined as follows:

- The department assigns a day procedure group to each Medicaid visit as specified in the day procedure group (DPG) ambulatory surgery classification system developed by the Canadian Institute for Health Information (CIHI). The day procedure group system is an ambulatory surgery classification system that assigns patients to one of 66 groups according to the principal ICD-9-CM procedure code recorded on the UB-92 claim form.

- The department determines a fee for each day procedure group which reflects the estimated cost of hospital resources used to treat cases in that group relative to the statewide average cost of all Medicaid cases. Fees for day procedure groups for sole community hospitals and non-sole community hospitals are specified in the department's outpatient hospital fee schedule.

The payment for Ambulatory Surgery services is an all inclusive bundled payment per visit which covers all outpatient services provided to the patient, including but not limited to nursing, pharmacy, laboratory, imaging services, other diagnostic services, supplies and equipment and other outpatient hospital services. For purposes of outpatient hospital ambulatory surgery services, a visit includes all outpatient hospital services related or incident to the ambulatory surgery visit that are provided the day before or the day of the ambulatory surgery event. Physician services are separately billable according to the applicable rules governing billing for physician services. Payment for certified registered nurse anesthetists (CRNAs) will be based on cost as a pass through in the cost settlement.

For hospital ambulatory surgery services, day procedure groups determined by the department to be unstable will be reimbursed a stop-loss payment. If the provider's net usual and customary charges are more than 500% or less than 75% of the fee specified, the day procedure group is unstable and the net charges will be paid at the statewide cost to charge ratio. For purposes of the stop-loss provision, the provider's net ambulatory surgery charges are defined as total usual and customary claim charges less charges for any non-covered services.

If the department's outpatient hospital ambulatory surgery fee schedule does not assign a fee for a particular DPG, the DPG will be reimbursed at the statewide average outpatient cost to charge ratio.

Ambulatory surgery services for which the primary ICD-9-CM procedure code is not included in the day procedure grouper, will be reimbursed under the retrospective cost basis.

7. STATEWIDE OUTPATIENT COST-TO-CHARGE RATIO

The Medicaid outpatient hospital statewide average cost to charge ratio equals 56 percent.

C. FACILITIES SUBJECT TO OUTPATIENT HOSPITAL REIMBURSEMENT

In-State Hospitals include large referral hospitals, other DRG hospitals, isolated hospitals, and critical access hospitals. Such hospitals may be additionally classified as disproportionate share hospitals, rural hospitals, sole community hospitals, and hospitals providing outpatient psychiatric services.

Border Hospitals are those hospitals which are located within 100 miles of the border of the state of Montana.

D. FACILITIES SUBJECT TO PERCENTAGE OF BILLED CHARGES REIMBURSEMENT METHODOLOGY

For dates of service on/after March 1, 2001, the facilities listed in Subsection D are reimbursed 61% of billed charges for medically necessary services.
Out-of-state Hospitals are those hospitals which are located beyond 100 miles of the border of the state of Montana.

Border Hospitals which provide services that are not available in Montana to a major portion of Montana Medicaid recipients.

E. QUALIFIED RATE ADJUSTMENT (QRA) PAYMENT

In accordance with the Code of Federal Regulation, "447.321 Outpatient hospital and clinic services: Application of upper payment limits, (2) Non-State government-owned or operated facilities (that is, all government facilities that are neither owned nor operated by the State), a hospital located in Montana meeting this definition may be eligible for a Qualified Rate Adjustment payment. If the eligible hospital's most recently reported costs multiplied by 150% (Upper Payment Limit) are greater than the Montana Medicaid allowed payment for outpatient care, the eligible hospital will receive a Qualified Rate Adjustment payment of the difference. The submitted cost reports from eligible hospitals and information from the paid claims database will be used for calculations. The QRA payment must be for services (paid claims) on or after July 1, 2001. Within the contract period between the Department and the eligible hospital, the Department will reconcile to ensure the Medicaid allowed and the QRA payments do not exceed the facility's Upper Payment Limit per year.